



ACCIDENTAL/ SERIOUS ILLNESS

APPLICATION FORM			
BROKER NAME :		INCEPTION DATE REQUIRED:	
ACCIDENTAL MEDICAL		SERIOUS ILLNESS	

PERSONAL DETAILS			
Surname:	Title:	Male	Female
First Names:			
Postal Address:			
Postal Code:			
Residential Address:			
Postal Code:			
Telephone Number (home):		Telephone Number (work):	
Cellular Number:		Fax Number or e-mail:	
Occupation:	Married	Divorced	Single
			Widowed
Date of Birth:		Citizenship / Nationality:	
Identity Number:		Signature:	

EXISTING MEDICARD HOLDER?	Yes:	No:	Card No:
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FAMILY MEMBERS TO BE COVERED: (NO COVER FOR CHILDREN UNDER THE SERIOUS ILLNESS PROTECTION PLAN)				
First names	I.D No or D.O.B.	Spouse or Child	State if living with you	
			Yes	No
		Spouse	Yes	No
		Child	Yes	No
		Child	Yes	No
		Child	Yes	No
		Child	Yes	No
		Child	Yes	No

Please give the name and address of your general practitioner as well as any specialist you may have recently consulted.

Doctor's name:	Specialist's name:
Address:	Address:
Phone no:	Phone no:

STATE WHETHER YOU OR YOUR DEPENDANTS HAVE EVER BEEN TREATED OR ARE CURRENTLY RECEIVING TREATMENT FOR ANY OF THE FOLLOWING ILLNESS INCLUDING BUT NOT LIMITED TO:			
1	Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia	Yes	No
2	Cancer, growths or tumours whether benign or malignant	Yes	No
3	Cardiovascular disorders, e.g. heart conditions, chest pain, coronary artery disease, high blood pressure, varicose veins, poor circulation	Yes	No
4	Endocrine disorders, e.g. high cholesterol, diabetes, thyroid abnormalities	Yes	No
5	Eye related disorders, e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts	Yes	No
6	Gastro-intestinal disorders, e.g. recurrent indigestion, ulcers, bowel disorders, gallbladder disorders, liver disorders	Yes	No
7	Gynaecological and obstetrical disorders, e.g. ectopic pregnancy, caesarean section, fibroids, endometriosis, menstrual irregularities, abnormal pap smear	Yes	No
8	Musculo-skeletal disorders, e.g. arthritis, back problems, gout, osteoporosis, joints, e.g. knee, shoulder, etc.	Yes	No
9	Neurological disorders, e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue	Yes	No
10	Psychological disorders, e.g. anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit	Yes	No
11	Renal (kidney) disorders, e.g. blood in urine, kidney stones, recurrent infections, kidney failure	Yes	No
12	Respiratory disorders, e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema, tuberculosis	Yes	No
13	Skin disorders, e.g. eczema, psoriasis, melanoma, skin cancer	Yes	No
14	State whether you or any of your dependants, have received medical advice or treatment for any infectious diseases, e.g. gonorrhoea, genital herpes, syphilis, TB, hepatitis or tested positive for HIV (AIDS)	Yes	No
15	Are you or any of your dependants currently pregnant? If so, please specify the expected date of delivery	Yes	No
16	Do you or any of your dependants expect to receive any treatment, or surgery in the next 12 months and do you or your dependants expect to be, or are currently, hospitalized?	Yes	No
17	Do you or any of your dependants currently receive or expect to receive treatment with any type of medication for longer than 3 months?	Yes	No

